DOCUMENT RESUME

ED 234 951 RC 014 338

AUTHOR Ackerman, Alan; Simkovic, Jeff
TITLE Special Migrant Initiative. 1982 Survey to Compare the Health Status of Migrants with Local Residents. Final Report.
INSTITUTION Sunrise Community Health Center, Inc., Greeley, CO.nt
PUB DATE Apr 83
NOTE 15p.
PUB TYPE Reports - Research/Technical (143)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Comparative Analysis; Dental Evaluation; Diabetes; Economically Disadvantaged; Family Planning; *Health Education; *Health Needs; Hispanic Americans; Hypertension; Infants; Migrant Children; *Migrant Health Services; *Migrant Problems; Migrant Welfare Services; Nutrition Instruction; Place of Residence
IDENTIFIERS Colorado; Health and Nutrition Examination Survey; Health Attitudes

ABSTRACT

A northern Colorado survey investigated whether migrants have better or worse health than the local poor population. An availability sample of migrants (202 adults, 101 children) was obtained by contacting migrants who had used Sunrise Community Health Center (Greeley, Colorado) within 24 months and by asking them to indicate other migrant families possibly interested in the free health screenings. The availability sample of local residents (66 adults, 64 children) was obtained by randomly selecting Center patients from the previous quarter and by randomly selecting households in low-income neighborhoods with high Hispanic populations. Survey questions were adapted from Health and Nutrition Examination Surveys. Findings for adults indicated need for increased screening among migrants (specifically for anemia in women, hearing and dental problems, diabetes, and hypertension), population. An availability sample of and for dental education programs, routine eye examinations, and hypertension education/control programs. Findings for migrant children included need for nutrition education concerning proper weaning techniques; routine lead screening (particularly for anemic children); and greater outreach for dental care. Overall conclusions were that migrant adults' health was as bad as or worse than the health of local residents, and, where health levels were the same, migrants perceived themselves as healthier than the local group, presumably because migrants are less highly educated about health conditions appropriate for good health. (MH)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED234951

David Simmons, M.D.
Medical Director

Louie Campos
Executive Director

JUN 1983
RECEIVED
ERIC/CRESS

sunrise community health center, inc.

FINAL REPORT
SPECIAL MIGRANT INITIATIVE

1982 Survey to Compare the Health Status of Migrants With Local Residents

RC014338

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

✓ This document has been reproduced as received from the person or organization originating it.
Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Alan Ackerman

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Authors

Alan Ackerman, Ph.D.
Principal Investigator

Jeff Simkovic, MBA
Principal Investigator

ACKNOWLEDGEMENTS

This survey was conducted through the help of many individuals. Hundreds of hours were spent in the design, collection and analysis of information. Jeff Simkovic assisted greatly in instrument design and analysis. Dorothy Rodman, Mary Lou Sandoval, Jennifer Leonard and other nurses from Sunrise Community Health Center served long evening hours in the field teams. Nancy Lewis, as field outreach worker, provided skills and energy in contacting and interviewing migrant and local families. David Smith, a medical student from the University of Colorado Medical School, examined migrant adults and children and contributed to this study as part of his preceptorship. Ann Gonzales provided for our typing needs along with Karen Nelson and Suzanne King. David Simmons, M.D., provided guidelines for referral protocols for patients identified through the survey procedure and Gloria Kramb, MT, provided expert lab support for the field teams. Louie Campos provided excellent administrative support for the design and maintenance of the program as did Charlene Harris in the day-to-day financial management of the project. It is impossible to name all who have helped in the implementation of this survey, but to all those, both mentioned and unmentioned, we express our deep thanks for a job well done.

Special thanks are due to Edward Cronin, M.D., who as Medical Director at the inception of this project, spent many hours working on preliminary proposals and early drafts of the interview instrument.

Alan Ackerman
Jeff Simkovic
April 1983

SUNRISE COMMUNITY HEALTH CENTER
1028 5th Avenue
P. O. Box 245
Greeley, Colo. 80632

TABLE OF CONTENTS

INTRODUCTION 1
SAMPLE SELECTION 1
INSTRUMENT 2
SAMPLE SIZE 3
FINDINGS FOR ADULTS 3
ACCESS TO HEALTH CARE 4
HEARING 4
DIABETES SCREENING 5
DENTAL HEALTH 5
HIGH BLOOD PRESSURE 6
ANEMIA 6
FAMILY PLANNING AND OB/GYN DATA 6
USE OF FOOD STAMPS AND COMMODITIES 7
FINDINGS FOR CHILDREN 7
BIRTH RELATED INFORMATION ON MIGRANT CHILDREN 7
FEEDING PRACTICES FOR INFANTS 8
EMPACHO AND THE USE OF LEAD OXIDES 8
DENTAL HEALTH 9
POLICY IMPLICATIONS FOR MIGRANTS - CLINICAL AREA 9
POLICY IMPLICATION FOR MIGRANTS - ADMINISTRATIVE CONSIDERATIONS .. 10
OTHER FINDINGS 10
A COMPARISON OF USERS VS NON-USERS OF SUNRISE COMMUNITY HEALTH CENTER ON A SERIES OF HEALTH MEASURES
CONCLUSIONS 11

INTRODUCTION

The purpose of the survey was to address the question: do migrants have better, worse, or the same health status compared to a matched sample of the local poor population. The funding for this survey, $15,000, was provided through a migrant health initiative grant. The findings of the study have policy implications, not just for Sunrise Community Health Center, but also for the conduct of health care in migrant centers in other areas.

Sample Selection

The design of the survey is such that generalization to a national sample is not strictly possible. Nevertheless, the large size of the migrant sample and the methodology used to select the local sample let us draw conclusions about this particular sample of migrants in northern Colorado. For the migrant population, we selected from the records of migrants who had used the clinic in the last twenty-four months. Their records were pulled and those with local addresses were included in the sample universe. As many migrants as possible were contacted through this method. Usually, the migrant's health record was for only one member of the family. We were able to examine the entire family and also other household members. By this procedure, we found many other adults and children who did not use Sunrise Health Center. We also asked the migrant families we interviewed, at the end of the interview, to indicate other migrant families who might want to participate in the free health screenings, which were part of the survey. These migrant-to-migrant referrals, from one migrant family to another, formed the remainder of our migrant universe sample. Selection of migrant individuals within this sample has to be considered an availability sample. Approximately an equal number of the migrant sample was drawn from these two selection procedures.

Selection of local sample initially was designed as a random selection procedure. However, because we did not control for refusal rate, we must also consider this an availability sample. We began selecting the local sample by randomly selecting names from the patient visit record for the previous quarter. Appointments were made with these randomly selected families and these families were then interviewed in their homes in the evenings. All the migrant interviews were conducted in the evenings, as well in the field sites. The remainder of the local sample was drawn by random selection of household units within low-income neighborhoods that had high Hispanic populations. Approximately half of the local sample was drawn by each of these two methods. Thus, our sample selection had two goals: One goal was to compare migrants to non-migrants and the other was to compare users and non-users of Sunrise Health Center services.

Instrument

The instrument which we used in this survey is available on request. The design of this survey instrument is based upon questions asked in the HANES surveys. HANES stands for Health And Nutrition Examination Surveys, which have been conducted by the National Center for Health Statistics. These surveys have developed an extensive methodology for assessing health of individuals. We adapted the HANES questions to a format which an adult could answer for themselves and the children in the family. Adults were questioned individually in the survey on their own health status. Children under 12 were answered for by the parents or guardians. In almost all cases, it was the mother who answered the survey questions for the children.

The survey questionnaire was designed so that three different items could be principally used as independent variables. These items were:

1. Migrant vs non-migrant status;
2. Use of Sunrise Health Center within the last twenty-four months; and
3. If an adult had seen a doctor in the last twelve months.

The dependent variables included both self perceptions of health status and specific evaluations by trained medical care teams of nurses and occasionally a nutritionist of the status of the individual. Status measures included blood pressure, condition of teeth, eye examinations, if the person had ever had specific screening tests, blood sugar levels, and other items which were mentioned in the summary of results.

The design of the independent variables allows us to report on three types of results. We have information on measures of:

1. Self perception of health by migrants and locals. In general, local groups perceive their health as worse than the migrant population. We also have measures of:
2. Actual health status as defined by:
   A. Frequency of screening, whether individuals had ever come in contact with health care systems and;
   B. Actual measures of health status. In general, the migrants had worse health status than the local population, although they perceive themselves to be more healthy than that population. We also have:
3. Information on individuals who do and don't use medical care and their health status. This information provides us with a measure of the effectiveness of health care offered by Sunrise Health Center.

The design of the questionnaire based on the HANES questions, allows our data, at some future point, to be cross-referenced with information on a nationally based sample of approximately the same education level.

SAMPLE SIZE

Our sample size was large enough that we have confidence that our results speak accurately to the health needs of the migrants in our areas. Our migrant sample was 303, including 202 adults and 101 children. Our local sample, which was selected with more attempt to provide randomness, included 66 adults and 64 children.

FINDINGS FOR ADULTS

Our sample of adults, migrant and local, was about evenly divided between men and women. There was no significant difference in the distribution of the ages of adults between the migrant and the local population. Thus, the two samples seem to be matched well on those criteria. However, locals were significantly more educated than migrants, both in terms of years of school attended or years of school completed. Locals had completed 9 years of school, migrants only 6 years.

All 66 local adults considered Greeley their permanent home, while only eight of the 202 migrants considered Greeley to be their permanent home. All of the other migrant adults named distant locations as their permanent homes. The majority, 80% of these, were locations in Texas. Only a small percentage indicated they lived in other sites in Colorado. The remainder came from other locations, including Arizona, Nebraska, Utah, California and Mexico. Approximately eight percent of the migrant adults did not indicate a permanent residence.

One key finding which was significant between migrants and locals was that migrants lived in lower quality housing than the local population. Migrants are significantly more likely to be without running water. Migrants are significantly more likely to have inadequate or no screening on the home they live in in Colorado. Migrants were more likely to have no phone in their residence and to live more than a quarter of a mile from a phone they could use. All of these findings are highly significant and detailed information is given in Table One below.

Table One

	Migrant	Local
No running water	11%	0%
No hot water	13%	1.5%
Inadequate or absent screens	24.5%	1.6%
No phone	84%	26%
Phone which can be used within ¼ mile of residence	27%	94%

Another demographic difference between migrants and locals was that migrants were more likely to speak only Spanish or Spanish plus English, compared to locals who more likely spoke Spanish plus English or English only.

ACCESS TO HEALTH CARE

Locals were much more likely to use health care at Sunrise Health Center than were migrants. Fifty-nine percent of the migrant adults had not used Sunrise in the last two years. compared with only 20% of locals. Although there were no other major differences between migrants and non-migrants in their perception of access to medical care, both groups showed poor utilization of medical services. When asked if they would like to see a doctor on the day of the survey, 28% of both the migrants and the locals said they wanted to see a doctor on that day. When asked the reason why they wanted to see a doctor, the migrants gave much more specific reasons for their need to see a doctor while the locals gave more vague reasons, including a higher percentage of unclassifiable symptoms. This tendency to specify a specific problem for which to see the doctor was significant with more migrants showing greater need to see a doctor on the day of the survey. Interestingly, the migrants who wished to see a doctor on the day of the survey were most likely those migrants who had not used Sunrise and who have not seen the doctor in the last year. It was also the migrants who did not use local health care who most wanted to see a doctor on the day of the survey for specific complaints, which needed treatment.

Locals were more likely to have stayed in the hospital during the last year. Three times as many locals as migrants were hospitalized in the last twelve months. This measure either indicates that migrants are much more healthy than the local population or that they are hospitalized less often because of poor access to care. Indeed, those migrants who used Sunrise Community Health Center were hospitalized at about the same rate as the local population. It was migrants who did not use local health care who were hospitalized less often than the local group. This group also had specific complaints which they wanted treated on the day of the survey. Thus, we favor the hypothesis that individuals who are not using health care are less likely to be hospitalized, even if they need to be.

HEARING

Migrants were much more likely never to have had their hearing tested. Fifty-six percent of the migrants reported that they never had their hearing tested compared to 31% of the locals. However, the migrants who have had it tested, had it tested recently. This indicates that the younger migrant adults who have had their hearing tested have had it tested more recently, possibly in connection with public school attendance.

DIABETES SCREENING

Only 2.5% of migrants had known diabetes before this survey was conducted compared to 11% of the local population. However, screening for blood glucose using only overweight adults, picked up an additional 3% of migrants who had diabetes. Since only overweight adults were screened, and 17% of these screenings gave a positive result for elevated blood glucose, the strategy of only screening overweight adults may be useful in evaluating diabetes in migrant populations. The conclusion is that migrants are much more likely than locals to have elevated blood sugar that was unknown to them.

DENTAL HEALTH

Migrant adults were much more likely never to have seen a dentist. Forty-two percent of the migrant adults had never seen a dentist compared to 11% of the local population. Migrants who did see a dentist saw one more recently than locals. However, migrants tended to rate their teeth in better condition to locals, even though on the average, they tended to need more dental work than locals.

Migrants also tended to be more uncertain that their teeth needed cleaning. This is particularly interesting, given the fact that a significantly greater percentage of migrants never had their teeth cleaned. Sixty-nine percent of migrants versus 25% of locals never had their teeth cleaned. While a majority of both the local and the migrant groups thought they needed a dental check-up, it is not surprising that less than 5% of either group had an appointment for one on the day of the survey. In addition, locals were much more likely to have an appointment on the day of the survey than the migrants, if they used medical care at Sunrise Health Center. Of those who had their teeth cleaned ever, there was no difference between migrants and locals and how long ago they had had it done.

Migrants were more likely to be uncertain that they needed to have a tooth filled than the local population even though they tended to have more dental caries than the local population. Twelve percent of the migrants and 17% of the local group respectively felt they needed a tooth pulled and 32% of the migrants and 43% of the local populations thought they needed a tooth filled. This is interesting in response to the fact that it was the migrant population that had more gross tooth decay and probably more need to have teeth pulled than the local population. Locals were more likely to report problems that interfered with their eating. Twenty percent of the locals versus 7% of the migrants reported problems with eating and over 90% of these problems reported had to do with the condition of their teeth and gums. This may be a function of the higher education level of the local population. Migrants have more carrious teeth with a greater amount of average decay than the local population, although the difference between the amount of decay per person in the two groups was not significant.

HIGH BLOOD PRESSURE

Seventeen percent of both the local and the migrant adult population had uncontrolled high blood pressure, defined as one of the parameters above the normal limit: i.e., systolic greater than 140 or diastolic greater than 90 or both. Approximately 4% of the migrants and 4% of the locals had taken high blood pressure medication during the last six months.

ANEMIA

Twelve percent of migrant women and 12% of local women who were screened for anemia were found to have a hemotocrit less than or equal to 35 and were classified as anemic. However, a greater percentage of the migrant women did not know that they were anemic.

FAMILY PLANNING AND OB/GYN DATA

Concerning family planning, seventeen percent of sexually active migrant women were currently taking birth control pills and 19% of local sexually active women were taking these pills. However, of women using other methods of family planning, only 31% of migrant women were using such methods compared to 64% of local women; thus a total of 48% of the migrant women were using some form of family planning, while a total of 83% of the locals were using some form of family planning. Of those women not using any form of family planning, one out of every four wanted to contact a physician about family planning services. These individuals were advised of the availability of family planning services through the clinic. Thus, in total, 10% of the migrant women wanted to have more information about family planning compared to 3% of the local women.

Migrant women in this survey were more likely to be pregnant at the time of the survey. Nine percent were pregnant versus 0% in the local population. Interestingly, there was no difference in the average number of pregnancies which migrants and locals had had. Both groups had an average of more than six pregnancies per women. The fetal wastage rate, which is the total of miscarriages and stillbirths, divided by the total number of pregnancies was high in both groups, averaging 20-22%. Thirty-nine percent of the migrant women had never had a pap smear, compared to 14% of the local women. This difference is probably due to the large number of teenage sexually active women in the migrant population. Of those who had had a pap smear, 21% of the migrant women had had it longer than two years ago, compared to 12% of the local women. Two times as many migrant women had never had a breast examination by a doctor; 25% vs 12%, and two times as many migrant women did not examine their own breasts each month; 36% vs 18%.

USE OF FOOD STAMPS AND COMMODITIES

While the income levels assumed for our samples would indicate that they should be eligible for federal food assistance, less than half the migrants and less than half the locals had qualified for food stamps. It is not possible from our data, since we did not collect actual income levels, to judge whether or not this is an actual under-utilization of the food stamp program by both groups, although we suspect that there is under-utilization of the food stamp program. Of those pregnant women or women with young children who are eligible for the special commodities supplemental food program in Weld County, 2/3 of the migrants and 3/4 of the locals were receiving the commodities. Those who used local health care were more likely to be involved in the commodities program. Thus, there is still under-utilization of the commodities supplemental food program by migrants, with a third of the eligible migrant women not using the program and a quarter of the eligible locals not receiving commodities under the program.

FINDINGS FOR CHILDREN

Migrant children have essentially the same demographic pattern as migrant adults, which is not surprising considering migrant children live in the same homes as the migrant adults.

BIRTH RELATED INFORMATION ON MIGRANT CHILDREN

Low birth weight is defined as a birth weight less than 5.5 pounds. Based on the maternal reported birth weight, 8.6% of migrant babies weighed less than 5.5 pounds compared to 3.5% of the local babies. Thus, nearly twice as many migrant babies were premature by birth weight as reported by their mothers. It is important to note that this reporting of birth weight is for all pregnancies that the mother has. The period of time covered may be several decades in some cases. High birth weight, greater than or equal to 9 pounds, is an indication of a high gestational diabetes risk for the mother, and it gives a risk of increased fetal complications at birth. Twenty-nine percent of the migrant children born to migrant mothers in this survey were reported to weigh more than 9 pounds, compared to 7% of the local sample. It is important to note that this does not mean that 29% of migrant mothers are at risk for gestational diabetes because several mothers in the sample had more than one child weighing more than 9 pounds. Approximately 20% of the migrant mothers were high risk for gestational diabetes by this criteria. For prematurity by date, 8% of the migrant babies and 7% of the local babies were reported to be born prematurely by dates. Another risk factor related to pregnancy is the age of the mother at the birth of the baby. Interestingly, 18% of the local population were teenagers when one of their babies was born compared to 12% of the migrant sample. However, when the risk factor for the age of the mother being over 35 is examined, 13% of the migrant mothers gave birth to a baby when the mothers

were older than 35 compared to only 3.5% of the local sample. All of these factors except for the higher rate of teenage birth in the local sample, indicate that the migrant mothers are more at risk for pregnancy complications than the local mothers.

FEEDING PRACTICES FOR INFANTS

Information on the feeding practices in infancy indicate that the migrant families wean the child to a cup later than the local families. Also, there is evidence that both the local and migrant families delay weaning from the bottle for too long a period, with one out of every eight children, regardless of whether they are migrant or local, being weaned from the bottle after 24 months, with occasionally some being weaned as late as six years.

EMPACHO AND THE USE OF LEAD OXIDES

Concerning the treatment of empacho the belief is that empacho is caused by having food stick to the stomach lining. In some cases, specific foods which are believed hard to digest, such as popcorn, cause empacho. In the migrant and the local population we found that 50% of the migrant children under the age of twelve have been treated for empacho compared to 17% of the local children. The types of treatment differed significantly, with the locals using four types and the migrants using twelve types. There was some overlap between the types of treatments the locals and the migrants used, with two of the four types being similar. Three types of treatments which were volunteered by the migrants without previous questioning about azarcon* or greta** involved the use of lead oxides. In other words, three of the types of treatments involve the use of azarcon, greta, or a combination called azarcon-visnuta.

Seven out of the 100 migrant children in the survey had received either azarcon or greta in some form; a lifetime prevalence rate among migrant children in our sample of 7% exposure to lead oxides. However, none of the lead oxides had been used within a period of the previous 18 months. The child who had received greta 18 months ago had a blood lead of 15 micrograms per 100 ml, which is within normal limits. This is not surprising, considering that the body can clear lead at a rate of about 100 micrograms per day. Since only one-half of the children were treated for empacho treatment, seven out of the 50 empacho treated children had received lead. Thus, among children who are treated for empacho in the migrant stream in Colorado, 14% of those children were treated with lead oxides, apparently. Interestingly, none of the seven children who had been treated with azarcon or greta had used the Sunrise Community Health Center in the past twenty-four months, and it may be important to look for azarcon and greta associated blood lead elevations in non-routine child care.

We also reorganized our data to examine whether empacho treatment predicted anything about other aspects of the child questionnaire. We found several pieces of

interesting data which are difficult to interpret. Children who were treated for empacho seemed to have a higher birth weight with a greater percentage of empacho treated children weighing more than nine pounds. Empacho treatment seemed to be associated with later weaning, both from the bottle and to a cup. Also, although migrant and local children had about the same chance of having had their eyes examined, there was a significantly greater percentage of empacho treated children who had eye glasses compared to those not treated. The policy significance of these findings is unclear, although the findings are statistically significant.

*Azarcon - Pb_3O_4
**Greta - PbO or Pb_2O_3

DENTAL HEALTH

Forty-three percent of migrant children had at least one caries compared to 31% of local children. Migrant children had an average of 2.12 caries per child compared to an average of 1.78 caries per child in local children. Our data indicates that the dental health of migrant children under the age of 12 is still a little worse than that of our local population. This difference persists even with the intensive outreach efforts that are undertaken to repair the teeth of migrant children and with the high priority migrant children have over local children in the receipt of dental care services. We suspect that these differences persist in our area because many of the migrant children do not attend migrant schools where the majority of the dental screening and repair is initiated.

POLICY IMPLICATIONS FOR MIGRANTS - CLINICAL AREA

1. Adults -

   There is a need for increased screening among the migrant population; specifically for hearing, dental screening of adults, screening for diabetes mellitus in overweight adults, screening for anemia in adult women. Migrant adult families might benefit highly from a dental education program. Migrants would benefit from routine eye examinations. Migrant adults would benefit from hypertension education and control programs and there is a need to maintain a hypertension screening program with the migrant population.

2. Children -

   Migrant infants and children would benefit from a nutrition education program concerning proper techniques of weaning. Migrant children could benefit highly from routine lead screening and all anemic migrant children probably should be screened for lead toxicity. Migrant children need greater outreach in terms of dental care.

POLICY IMPLICATIONS FOR MIGRANTS - ADMINISTRATIVE CONSIDERATIONS

1. There appear to be a number of significant areas of difference between migrants and local groups of approximately the same social position. These differences would appear to justify the continuation of special funding for migrant projects directly from federal sources rather than the block granting of funds through local sources. The block grant is designed as the transfer of funds to the State for local decisions concerning expenditure of those funds. Local sources should be expected to address their own perceived needs first and these needs do not match well with the needs of the migrants.

2. The Office of Migrant Health should initiate other studies using our methodology to replicate our findings in other sites in the migrant stream. If these findings are shown to be accurate in other sectors as well, the National Office of Migrant Health should administratively take policy steps to improve migrant health status along the lines documented in clinical areas 1 and 2 above.

OTHER FINDINGS

In general, the sample procedure found that adult migrant men, particularly older adults, were unreceptive to offers of free medical screening and seemed to show culturally based attitudes concerning the inappropriateness of modern medical care for them. More research needs to be done on methods of incorporating this reluctant sub-group into the medical care system.

An interesting finding of the survey related to questions concerning gastrointestinal complaints of a chronic nature. These HANES questions are designed as measures of long term gastro-intestinal symptoms of difficulty swallowing, nausea, vomiting or abnormal pain. On a set of four questions concerning difficulty swallowing, nausea, vomiting and chronic abdominal pain, only the migrants answered these questions positively. No locals answered them positively. The rates at which the migrants answered these questions affirmatively were too low to be significant for our size sample. These questions may be good indicators of chronic low level pesticide exposure and research should be done to investigate this possiblity. Based on our sample size, the calculated rates per 1,000 for chronic complaint were difficulty swallowing 10/1,000; nausea alone 30/1,000; vomiting 15/1,000; chronic abdominal pain 45/1,000.

A COMPARISON OF USERS VS NON-USERS OF SUNRISE COMMUNITY HEALTH CENTER ON A SERIES OF HEALTH MEASURES.

The following table indicates differences between users and non-users of Sunrise Community Health Center, disregarding whether or not they were migrants. It is important to remember that many more migrants than non-migrants did not use Sunrise Community Health Center for their local care. It is also important to remember that the person is designated a Sunrise Community Health Center user if they had used Sunrise Center once during the last 24 months for any reason.

Comparison of Adult Users vs Non-Users

	Users	Non-Users
Increased Blood Pressure	14%	24%
Anemic	18%	14%
Gross Tooth Decay	37%	47%
No Pap Within Last 24 Months	13%	26%
Uses Family Planning Method	57%	29%
Has Eyeglasses	32%	10%

This data indicates that users of health care have better health care profiles than non-users. Thus, the conclusion to be drawn is that there is an under-utilization of care in the migrant population. This under-utilization of care derives in part from the perception of the migrants that they are generally healthy, when in fact, compared to appropriate health care standards, their health falls below what should be expected. Additional research should be conducted on this data concerning which factors account for the majority of the variance between migrants and non-migrants. In addition, it would be useful to compare this data to a HANES sample on similar questions. The National Office of Migrant Health might be able to arrange for this comparison with the National Center for Health Statistics in HHS.

CONCLUSIONS

In all but a few cases, migrant health for adults is as bad or worse than the local population. Where the levels are the same as the local population, the migrants perceive themselves to be healthier than the local group, presumably because the migrant group is less highly educated about health conditions (than the local group) which are appropriate for good health. This finding supports the idea that there is a need to continue specific migrant health funding for migrant health clinics rather than to support a block grant approach for migrants. Migrants would not be perceived as being the responsibility for any given state, and thus, the exceptional needs of the migrant population could be inadequately addressed through the block grant process.